BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
Richard Leonard Gilliam, M.D.	)	**Case No. 800-2015-018082**
Physician's and Surgeon's Certificate No. G 85035	)	
Respondent	)	

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on October 25, 2019.

IT IS SO ORDERED: September 27, 2019.

MEDICAL BOARD OF CALIFORNIA

Ronald H. Lewis, M.D., Chair
Panel A

XAVIER BECERRA
Attorney General of California
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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **RICHARD LEONARD GILLIAM, M.D.** **2440 N. Fremont Street, #102B** **Monterey, CA 93940** **Physician's and Surgeon's Certificate** **No. G 85035** Respondent.	Case No. 800-2015-018082 OAH No. 2019020030 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Michael C. Brummel, Deputy Attorney General.

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2. Respondent Richard Leonard Gilliam, M.D. (Respondent) is represented in this proceeding by attorney Bradford J. Hinshaw, Esq., whose address is: 12901 Saratoga Ave., Saratoga, CA 95070.

3. On or about February 11, 1999, the Board issued Physician's and Surgeon's Certificate No. G 85035 to Richard Leonard Gilliam, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2015-018082, and will expire on April 30, 2020, unless renewed.

JURISDICTION

4. Accusation No. 800-2015-018082 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on September 17, 2018. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2015-018082 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2015-018082. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

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CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2015-018082, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges. Respondent agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in Accusation No. 800-2015-018082 shall be deemed true, correct and fully admitted by respondent for purposes of that proceeding or any other licensing proceeding involving respondent in the State of California.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

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13. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 85035 issued to Respondent Richard Leonard Gilliam, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES - PARTIAL RESTRICTION. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substances Act, except for those drugs listed in Schedules IV and V of the Act.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If Respondent forms the medical opinion, after an appropriate prior examination and medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that Respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully

document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

This restriction shall remain in effect until Respondent has successfully completed a Prescribing Practices Course as set forth below in Condition No. 4.

2. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all of the following: 1) the name and address of the patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

3. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

4. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board

or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

6. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

7. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless

the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

8. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree

to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a

notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

9. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

10. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

11. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

12. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

13. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

14. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

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15. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

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16. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

17. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

18. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

19. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Bradford J. Hinshaw, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 8/26/19

RICHARD LEONARD GILLIAM, M.D.
Respondent

I have read and fully discussed with Respondent Richard Leonard Gilliam, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 8-27-19

BRADFORD J. HINSHAW, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated:

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General

MICHAEL C. BRUMMEL
Deputy Attorney General
Attorneys for Complainant

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Bradford J. Hinshaw, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: _____

RICHARD LEONARD GILLIAM, M.D.
Respondent

I have read and fully discussed with Respondent Richard Leonard Gilliam, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: _____

BRADFORD J. HINSHAW, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: August 27, 2019

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General

Michael C. Brummel

MICHAEL C. BRUMMEL
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2015-018082

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Richard Leonard Gilliam, M.D.** PO Box 4451 CARMEL, CA 93921-4451 Physician's and Surgeon's Certificate No. G 85035, Respondent.	Case No. 800-2015-018082 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board").

2. On or about February 11, 1999, the Medical Board issued Physician's and Surgeon's Certificate Number G 85035 to Richard Leonard Gilliam, M.D. ("Respondent"). That Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2020, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code ("Code") unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code states, in pertinent part:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

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6. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

PERTINENT DRUG INFORMATION

7. Hydrocodone with acetaminophen – Generic name for the drugs Vicodin, Norco, and Lortab. Hydrocodone with acetaminophen is classified as an opioid analgesic combination product used to treat moderate to moderately severe pain. Prior to October 6, 2014, Hydrocodone with acetaminophen was a Schedule III controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.13(e). Currently, it is a Schedule II controlled substance.[1] Hydrocodone with acetaminophen is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055, subdivision (b).

8. Zolpidem Tartrate – Generic name for Ambien. Zolpidem Tartrate is a sedative and hypnotic used for short term treatment of insomnia. Zolpidem Tartrate is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

9. Clonazepam – Generic name for Klonopin. Clonazepam is an anti-anxiety medication in the benzodiazepine family used to prevent seizures, panic disorder and akathisia. Like all members of the benzodiazepine family, clonazepam can have a sedative effect. Clonazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c). It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

10. Lisdexamfetamine – Generic name for Vyvanse. Lisdexamfetamine is a substituted amphetamine and an inactive prodrug of the stimulant dextroamphetamine used for the treatment

[1] On October 6, 2014, Hydrocodone combination products were reclassified as Schedule II controlled substances. Federal Register Volume 79, Number 163. Code of Federal Regulations Title 21 section 1308.12(b)(1).

of attention deficit hyperactivity disorder (ADHD). The medication can be habit forming. Lisdexamfetamine is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12(d) and a dangerous drug pursuant to Business and Professions Code section 4022.

11. Tramadol – Generic name for the drug Ultram. Tramadol is an opioid pain medication used to treat moderate to moderately severe pain. Effective August 18, 2014, Tramadol was placed into Schedule IV of the Controlled Substances Act pursuant to Code of Federal Regulations Title 21 section 1308.14(b). It is a dangerous drug pursuant to Business and Professions Code section 4022.

12. Oxycodone – Generic name for OxyContin, Roxicodone, and Oxecta. High risk for addiction and dependence. Can cause respiratory distress and death when taken in high doses or when combined with other substances, especially alcohol. Oxycodone is a short acting opioid analgesic used to treat moderate to severe pain. OxyContin ER is a long acting opioid formulation consisting of an extended release mechanism sold under the brand name OxyContin. Oxycodone is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Oxycodone is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

13. Amphetamine Salts – Generic name for the drug Adderall, which is a combination drug containing four salts of the two enantiomers of amphetamine, a Central Nervous System (CNS) stimulant of the phenethylamine class. Adderall is used to treat attention deficit hyperactivity disorder and narcolepsy but can be used recreationally as an aphrodisiac and euphoriant. Adderall is habit forming. Amphetamine Salts are a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12(d) and a dangerous drug pursuant to Business and Professions Code section 4022.

13. Alprazolam – Generic name for the drug Xanax. Alprazolam is a short acting benzodiazepine used to treat anxiety. Like all benzodiazepines, alprazolam has a sedative effect. Alprazolam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title

21 section 1308.14. Alprazolam is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule IV controlled substance pursuant to California Health and Safety Code section 11057(d).

14. Morphine – Generic name for the drug MS Contin. Morphine is an opioid analgesic drug. It is the main psychoactive chemical in opium. Like other opioids, such as oxycodone, hydromorphone, and heroin, morphine acts directly on the central nervous system (CNS) to relieve pain. Morphine is a Scheduled II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Morphine is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

15. Diazepam – Generic name for Valium. Diazepam is a long-acting member of the benzodiazepine family used for the treatment of anxiety and panic attacks. Diazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

16. Oxycodone with acetaminophen – Generic name for Percocet and Endocet. Percocet is a short acting opioid analgesic used to treat moderate to severe pain. Percocet is a Schedule II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. Percocet is a dangerous drug pursuant to California Business and Professions Code section 4022 and is a Schedule II controlled substance pursuant to California Health and Safety Code section 11055(b).

17. Lorazepam – Generic name for Ativan. Lorazepam is a member of the benzodiazepine family and is a fast acting anti-anxiety medication used for the short-term management of severe anxiety. Lorazepam is a Schedule IV controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.14(c) and Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

18. Methadone – Generic name for the drug Symoron. Methadone is a synthetic opioid. It is used medically as an analgesic and a maintenance anti-addictive and reductive preparation

for use by patients with opioid dependence. Methadone is a Scheduled II controlled substance pursuant to Code of Federal Regulations Title 21 section 1308.12. It is a schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

19. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), in that he committed gross negligence during the care and treatment of patients 1, 3, 4, 5, and 6, in that he failed to properly prescribe controlled substances. The circumstances are as follows:

Patient 1[2]

20. On February 26, 2015, Respondent documented that he saw Patient 1 for the first time in his clinic. Respondent documented that Patient 1 wanted a second opinion regarding a diagnosis of epididymitis. Patient 1 reported pain in both testicles for the past eight months. He reported that he had no discharge, had painful ejaculation and ejaculated once a week. Patient 1 stated he had no hernias. Respondent documented a physical examination that indicated no hernias, tender left testicle much more than right, no varices, and no masses. Respondent at his subject interview with the Medical Board on May 8, 2018, stated that he believed Patient 1 was not taking any controlled medications as of February 26, 2015. Pharmacy records show that Patient 1 was actually receiving 30 tablets of 12.5 mg. zolpidem tartrate, and 30 tablets of 10 mg. amphetamine salts on February 4, 2015, from another medical provider. The pharmacy records also showed that Patient 1 had received 240 50 mg. tablets of tramadol on February 8, 2015, and 120 tablets of diazepam on February 10, 2015 from that same medical provider. It is noteworthy that Patient 1 received refills of all of these medications from that same medical provider after seeing Respondent on February 26, 2015. At that visit, Respondent prescribed 60 tablets of

[2] Identifying patient information has been removed from this Accusation to protect privacy. All witnesses will be fully identified in discovery. Patients 1 through 6 correspond with the patients as listed in the expert report that was commissioned by the Medical Board in this matter.

10/325 mg. hydrocodone with acetaminophen to Patient 1. Respondent didn't document a history and physical exam, and didn't document performing a substance abuse history which would have shown Patient 1's other controlled substance prescriptions. Respondent didn't document a treatment plan for chronic pain management, didn't document providing informed consent, including the risks and benefits of opiate therapy, and didn't order any additional testing to confirm Patient 1's diagnosis. At the subject interview on May 8, 2018, Respondent stated that Patient 1 was autistic, had psychological issues and that his father was often present and pushing for additional treatment but Respondent didn't document those facts in Patient 1's medical records.

21. Respondent next saw Patient 1 in his office on March 18, 2015. Respondent noted that Patient 1 had brought an MRI which showed no abnormality of the testicles. Respondent noted that Patient 1 had an appointment with urologist and that he was in acute pain. Respondent documented a physical examination that showed the left testicle very tender at the lower pole but otherwise the exam was normal. Pharmacy records showed that Patient 1 was still getting carisoprodol, tramadol, zolpidem tartrate, diazepam, and amphetamine salts from another medical provider. Respondent did not document that he was aware of those prescriptions. Respondent prescribed 60 tablets of 10-325 mg. hydrocodone with acetaminophen. Respondent didn't document a treatment plan of care for the use of opioids and didn't document that he tried non-pharmacologic therapies with Patient 1. Respondent didn't document a history, treatment plan or opioid risk assessment.

22. Respondent next saw Patient 1 on April 17, 2015, and on May 13, 2015, in clinic. Respondent prescribed 60 pills of 10/325 mg. hydrocodone with acetaminophen on April 17, 2015, and 70 pills of 10/325 mg. hydrocodone with acetaminophen on May 13, 2015. Respondent didn't note why he was increasing the prescription. Respondent didn't document a physical examination, didn't document a treatment plan, and didn't document that he was aware that Patient 1 was still receiving carisoprodol, tramadol, diazepam, and amphetamine salts from another physician. On April 17, 2015, Respondent had Patient 1 sign a controlled drug agreement that set forth informed consent including risks and benefits of controlled substances, and the

contract specifically notified Patient 1 that medications would not be refilled early, that Patient 1 would not receive controlled substances from any other provider except for Respondent with the only exception being medications prescribed at a hospital or on-call physician appointed by Respondent, and that violation of any term of the controlled drugs contact could be grounds for immediate termination of the prescriptions. A review of pharmacy records showed that between April 17, 2015, and January 7, 2016, Patient 1 continued to receive multiple prescriptions for tramadol, clonazepam, and, zolpidem tartratem, from another medical provider in violation of the April 17, 2015, controlled drug agreement. Respondent did not terminate Patient 1 despite these repeated violations.

23. On July 20, 2015, Respondent prescribed 240 tablets of 50 mg. tramadol and 60 tablets of 10/325 mg. hydrocodone with acetaminophen to Patient 1. Respondent documented that Patient 1 was still having testicular pain, that he was being seen for pain management by Respondent and that Respondent was prescribing tramadol because it "works well without making him spacey." Respondent documented that he would prescribe norco to be held in reserve. Respondent continued to not document a complete treatment plan for chronic pain therapy, didn't document a periodic review of whether opiate therapy was needed with this patient, and didn't document whether he recommended non-pharmacologic therapies to Patient 1.

24. On October 9, 2015, Respondent saw Patient 1 in clinic. Patient 1 was noted to be present for pain management, that he had testicular pain, that he had seen a urologist, and that he was taking norco for pain, and that tramadol worked well "without making him spacey". Respondent noted that Patient 1's pain level was 9/10. Respondent noted that Patient 1 stated that he "(f)eels the norco is not doing much and would like to try the Percocet he got in the ER." Respondent doesn't document any information related to Patient 1's reported ER visit, nor any of the circumstances that led to Patient 1 receiving Percocet. Respondent noted that Patient 1 was well nourished, well developed, and in no acute distress. Respondent didn't document a periodic review that tramadol and norco were no longer effective as described by the patient, nor did he document a comprehensive treatment plan for chronic pain therapy. Respondent began prescribing 90 tablets of 7.5/325 mg. oxycodone with acetaminophen and 240 tablets of 50 mg.

tramadol. At this point, Respondent was prescribing a Morphine Equivalent Dose[3] ("MED") of 83.75.

25. Respondent next documented that he saw Patient 1 in clinic on November 12, 2015. Respondent noted that Patient 1 was taking "norco for pain" despite discontinuing Norco on October 9, 2015. Respondent documented that Patient 1 "stopped taking tramadol." Respondent documented that Patient 1 reported "Percocet 7.5 was very hard to find. Would like to go up to 10 mg." Respondent also reported that Patient 1 stated, "valium has worked for pain and social anxiety so he would like that again." Respondent doesn't document a periodic review of Patient 1's treatment plan. Respondent prescribed 120 tablets of 10/325 mg. oxycodone with acetaminophen, and 60 tablets of 5 mg. diazepam. A review of pharmacy records shows that Respondent began prescribing 120 tablets of 10/325 mg. oxycodone with acetaminophen and 240 tablets of 50 mg. tramadol to Patient 1, and increased the diazepam prescription to 120 10 mg. tablets in February and March 2016. By that time, Patient 1 was receiving an MED of 110 along with 40 milligrams of diazepam a day. Respondent failed to document why he was titrating Patient 1 up from 90 tablets of 7.5/325 mg. oxycodone with acetaminophen to 120 tablets of 10/325 mg. oxycodone with acetaminophen.

26. Respondent continued to prescribe controlled substances to Patient 1 through May 2016. On May 13, 2016, Respondent documented that, "a friend called to say that (Patient 1) is probably addicted to drug(*sic*) and may be buying it on the street." On June 9, 2016, Respondent documented seeing Patient 1 in clinic. Respondent failed to document whether he discussed the contents of the May 13, 2016, phone message with Patient 1. Respondent noted on June 9, 2016, that Patient 1 had run out of Percocet two days early. Respondent failed to document a treatment plan for chronic pain therapy, a physical to support chronic pain therapy, or a periodic review of Patient 1's progress on chronic pain therapy. Respondent documented that Patient 1 reported a pain level of 10 but failed to review whether Patient 1 was receiving relief from pain therapy. Respondent continued to prescribe 120 pills of 10/325 mg. Percocet, 120 pills of 10 mg.

[3] An MED is a numerical standard against which most opioids can be compared, yielding an apples-to-apples comparison of each medication's potency.

diazepam, and 240 tablets of 50 mg. tramadol. On or about June 25, 2016. Respondent began prescribing 30 pills of 12.5 Ambien, another controlled medication that has sedative properties.

27. Respondent next documented that he saw Patient 1 in clinic on July 15, 2016. Respondent documented that Patient 1's pain level was "5/10" but goes up to 10. Respondent documented that Patient 1 had run out of Percocet a day early. Respondent documented that Patient 1 is interested "in taking long acting morphine and cutting back on short acting oxycodone," and for anxiety that, "valium works ok but things he did better on clonazepam." Respondent noted Patient 1 was having panic attacks and that Ambien was working well. Respondent didn't document performing a physical examination, or a periodic review of Patient 1's chronic pain treatment plan. Respondent prescribed 30 tablets of 1 mg. clonazepam, 60 tablets of 60 mg. morphine sulfate, and 240 tablets of 50 mg. tramadol. Respondent also refilled Patient 1's Ambien prescription. At this point Patient 1's MED was now 170, along with the prescription of two medications that have sedative effects, clonazepam and Ambien. Respondent noted that Patient 1's urine drug screen performed on June 9, 2016, was positive for THC, indicating that Patient 1 was consuming marijuana. Respondent did not document on July 15, 2016, whether he discussed his marijuana use as he was taking opioids and other sedatives. A review of the rest of the medical records between July 15, 2016, and October 14, 2016, continues to show that Patient 1 had positive drug tests for marijuana and continued to run out of medications early. Respondent failed to create a plan for chronic pain management, failed to perform a periodic review and failed to perform a physical to support the continued use of controlled substances in this patient. Respondent repeatedly documented that Patient 1's pain remained as high as 10 and was often 8 out of 10. Respondent did nothing to determine if the medications were improving Patient 1's functionality and life. A review of the medical records documenting Patient 1's care shows active cutting and pasting of information from previous notes.

28. At the subject interview with the Medical Board on May 8, 2018, Respondent admitted he had no medical records from Patient 1's prior treating physician before he began prescribing hydrocodone in February 2015. Respondent admitted that the only examination he

performed on Patient 1 before beginning chronic pain management was an examination of Patient 1's testicles. Respondent didn't perform a past substance abuse history; family history or complete systems review in April 2017 when he had Patient 1 enter into a controlled drug agreement and when he continued chronic pain management. Respondent acknowledged that he never received any records from specialists that he referred Patient 1 to confirm Patient 1's diagnosis of pain caused from testicles.

Patient 3

29. Respondent documented that he saw Patient 3 in clinic on October 27, 2013, for a cough. Respondent prescribed antibiotics and codeine cough syrup. Respondent continued to see Patient 3 for cough on February 10, 2014, and February 19, 2014. Both times he prescribed codeine cough syrup. On February 19, 2014, Respondent documented that Patient 3 was requesting a refill of Ativan which he was getting from another medical provider. Respondent documented that Patient 3 took Ativan for anxiety. Respondent documented performing a physical examination. Respondent didn't document performing a substance abuse history, medication history or neurological history related to the prescribing of lorazepam. Respondent didn't document a treatment plan, or document an appropriate evaluation before prescribing lorazepam. Respondent prescribed 60 tablets of 1 mg. lorazepam to Patient 3 with 4 refills. At the time Respondent began prescribing lorazepam to Patient 3, Patient 3 was receiving 150 tablets of 10/325 hydrocodone with acetaminophen and 120 tablets of 10 mg. methadone from a different medical provider. There are no medical records or documentation that Respondent spoke with the other medical provider or even knew that Patient 3 was receiving narcotics before he prescribed lorazepam, in particular whether lorazepam was appropriate while the other provider was prescribing methadone.

30. A review of pharmacy records showed that between February 2014 and March 2015, Respondent continued to prescribe lorazepam while another medical provider prescribed methadone, Percocet, and Norco to Patient 3. Respondent's medical records kept for Patient 3 from February 2014 to March 2015, are silent regarding the controlled substance prescriptions being prescribed by the other provider. For example, on August 13, 2014, Respondent noted that

Patient 3 needed a refill of the lorazepam he took for anxiety, and, that there are no side effects. There is no mention of the other controlled medications being prescribed. On October 31, 2014, Respondent documented that Patient 3 was present to refill the Ativan that he was taking twice a day but that Patient 3 had run out of the lorazepam early and he was unable to get an early refill at the pharmacy. Patient 3 requested that Respondent increase his Ativan prescription to 3 times a day. Respondent increased the prescription to 90 tablets of 1 mg. lorazepam per month at the patient's request. A substance abuse history was not performed, nor was there any documentation of Patient 3's other controlled substances. On January 14, 2015, Respondent documented that Patient 3 suffers from back pain and can't do any gainful employment. Respondent did not work up Patient 3's complaint of reported back pain. On April 1, 2015, Respondent saw Patient 3 in clinic. Respondent documented that Patient 3 was struggling with the death of his father, and that the lorazepam pills were not strong enough. Respondent doubled Patient 3's prescription from 90 pills of 1 mg. lorazepam per month to 90 pills of 2 mg. lorazepam per month. Respondent didn't document a treatment plan, didn't document a substance abuse history, and didn't provide any documentation that supported the doubling the lorazepam prescription.

31. On April 25, 2015, Respondent saw Patient 3 in clinic for a complaint of "refill pain meds." Respondent documented that Patient 3 had been seeing a pain doctor for back pain and that the pain doctor is out of town. Respondent documented that Patient 3 was reporting a pain level of 9 out of 10. Respondent documented that Patient 3 ran out of Norco. Respondent didn't document if Patient 3 had a pain contract with the other pain doctor, didn't document receiving any records from Patient 3's pain doctor that he was actually receiving Norco, didn't document whether Patient 3 was taking any other pain medications, and didn't document whether the 90 pills of 2 mg. lorazepam could have side effects with the consumption of Norco. Respondent prescribed 40 tablets of 10/325 mg. Norco to Patient 3 at the Patient's request.

32. On May 2, 2015, Respondent documented that Patient 3 was present for a lorazepam refill. Respondent noted that Patient 3's pain doctor was closing his office and that Patient 3 would like to come to Respondent's office for chronic pain management services. Respondent did not request records from Patient 3's pain doctor and refilled the lorazepam prescriptions. At

the time of this visit, Patient 3 was receiving 120 tablets of 10 mg. methadone and 90 tablets of 10/325 mg. oxycodone with acetaminophen per month from the other medical provider for an MED of 365. Respondent did not perform a substance abuse history.

33. On May 5, 2015, Respondent documented that he next saw Patient 3 in clinic. It appears from the medical records that Respondent took over Patient 3's chronic pain management care on May 5, 2015. Respondent noted that Patient 3's pain doctor was leaving town, that his pain level was 9/10 and that Patient 3 was feeling anxious. Respondent performed a brief physical examination which showed a moderately tender lumbar region. Respondent did not request records from Patient 3's pain doctor, did not perform a substance abuse history, did not perform a risk assessment, did not document creating a treatment plan, did not document a past history related to pain, including whether or not non-pharmalogical modalities had worked in the past, and Respondent did not work up Patient 3's back issues. Respondent prescribed 90 tablets of 10/325 mg. Percocet to Patient 3.

34. On May 29, 2015, Respondent documented that Patient 3 was back in the office to refill his Percocet prescription. Despite being six days early based on the 30-day prescription issued on May 5, 2015, Respondent prescribed 90 tablets of 10/325 mg. Percocet. There is no documentation regarding whether Respondent was concerned regarding this early refill request. Respondent also documented a second note regarding Patient 3's anxiety on May 29, 2015. Respondent documented that Patient 3 needed more lorazepam than the three 2 mg. pills per day that he was taking. Respondent increased Patient 3's lorazepam prescription to 120 tablets of 2 mg. lorazepam per month. There is no documentation that indicated Respondent provided informed consent for the prescription of opioids and benzodiazepines, including a heightened risk of respiratory depression at this visit or other visit with Patient 3.

35. Respondent next documented that Patient 3 was in clinic for pain medications on June 10, 2015. Respondent documented that Patient 3 was unable to get "methadone through me" and that he was willing to take OxyContin. Respondent noted that Patient 3's last methadone was 3 days ago and that Patient 3 had been taking more Percocet due to increased pain. Respondent didn't document why Patient 3 was receiving methadone, didn't document a substance abuse

history, didn't document a risk assessment, and didn't document providing informed consent before starting OxyContin. Respondent prescribed 20 tablets of 40 mg. OxyContin for a ten-day prescription.

36. Respondent next documented that he saw Patient 3 in clinic on June 18, 2015. At the time Respondent saw Patient 3 in clinic on June 18, 2015, he was prescribing 2 tablets of 40 mg. OxyContin per day, 3 tablets of 10/325 mg. Percocet, and 4 tablets of 2 mg. lorazepam per day to Patient 3. The MED on this prescription was 165. Respondent documented that Patient 3 had been seen in the ER (emergency room) because he presented drunk and refused admission for detox. Respondent noted that Patient 3 reported that he consumed 12 beers a day for the past several months, has a history of alcoholism, detox and AA meetings. Respondent noted that Patient 3 stated he has attempted to quit alcohol 4 times. Respondent noted that Patient 3 had a history of alcohol induced pancreatitis. Respondent documented a normal physical examination. Respondent began prescribing 30 tablets of 250 mg. Antabuse, a drug that interferes with alcohol consumption. Respondent also documented a second note for June 18, 2015, regarding Patient 3's pain management therapy. Respondent documented that Patient 3 was present to refill his OxyContin but that Patient 3 had been drinking excess alcohol resulting in an ER visit. Respondent didn't document whether he admonished Patient 3 about consuming alcohol while consuming pain medication.

37. Between June 18, 2015, and January 22, 2016, Respondent continued to prescribe lorazepam, Percocet, and OxyContin to Patient 3. During that time Respondent increased the dosages. Respondent also switched medications, between MS Contin and OxyContin. During that time, Respondent learned from Patient 3 that he was not taking Antabuse on the advice of his AA sponsor. Based on Respondent's documentation, he ignored repeated warning signs during that time regarding Patient 3's chronic pain therapy. On August 4, 2016, Respondent documented that Patient 3 was present for an oxycodone refill and that Patient 3 falsely claimed that Respondent had not refilled the prescription at the last visit despite medical record documentation that the prescription had been refilled. On August 17, 2015, Respondent documented that Patient 3 ran out of oxycodone, used up 28 Norco and that he also ran out of OxyContin before he was

scheduled to get a refill of his medications. Respondent documented that Patient 3 had a lot of back pain recently but failed to document whether he admonished Patient 3 regarding overuse of his medication, he didn't document a pain assessment, and he didn't document a periodic review of chronic pain therapy. Finally, Respondent documented that the OxyContin was working well but also documented that Patient 3's pain was 8/10 on December 23, 2015, and 9/10 on January 20, 2016. Respondent didn't document why Patient 3 would be reporting pain levels of 8/10 and 9/10 while on pain medication and didn't document assessing Patient 3's functionality on chronic pain medication. Respondent also cut and pasted the notes on many of the visits between June 18, 2015, and January 22, 2016.

38. On January 26, 2016, Respondent documented that he had Patient 3 sign a controlled drug agreement as part of his chronic pain management therapy. The controlled drug agreement set forth informed consent including risks and benefits of controlled substances, and the contract specifically notified Patient 3 that medications would not be refilled early, that Patient 3 would not receive controlled substances from any other provider except for Respondent with the only exception being medications prescribed at a hospital or on-call physician appointed by Respondent, and that violation of any term of the controlled drugs contact could be grounds for immediate termination of the prescriptions. Respondent did not document why he waited 7 months to have Patient 3 sign a controlled drug agreement after taking over Patient 3's chronic pain management therapy, nor did he document why he had waited to obtain Patient 3's informed consent before this date for chronic pain therapy.

39. Between February 2016 and May 2016, Respondent prescribed the following controlled substances to Patient 3.

Date Filled	Medication	Quantity	Dosage	Schedule
2-17-2016	Ativan	120 tablets	2 mg.	IV
2-17-2016	OxyContin	60 tablets	60 mg.	II
2-17-2016	Percocet	120 tablets	10/325 mg.	II
3-16-2016	Ativan	120 tablets	2 mg.	IV

3-16-2016	OxyContin	60 tablets	80 mg.	II
3-16-2016	Percocet	120 tablets	10/325 mg.	II
4-13-2016	Ativan	120 tablets	2 mg.	IV
4-13-2016	OxyContin	60 tablets	80 mg.	II
4-13-2016	Percocet	120 tablets	10/325 mg.	II
5-13-2016	Ativan	120 tablets	2 mg.	IV
5-13-2016	OxyContin	60 tablets	80 mg.	II
5-13-2016	Percocet	120 tablets	10/325 mg.	II

40. On February 17, 2016, Respondent documented that he refilled Patient 3's pain medication and that Patient 3 needed the prescriptions early because he was going on "house arrest". Respondent didn't bother to document why Patient 3 was going on house arrest and he provided refills for Patient 3's medication five days early. Respondent next documented that he saw Patient 3 in clinic for pain management on March 16, 2016. Respondent documented that "OxyContin 60 is working well. Pain level today in his back is 8/10." Respondent then documented that Patient 3, "(n)ot getting the pain relief he was getting from methadone and is asking for a higher dose of OxyContin." Respondent noted that Patient 3 had a tender lumbar area, but didn't document a full physical examination. Respondent didn't perform a substance abuse history, in particular specifically asking questions about Patient 3's alcoholism, didn't perform a periodic review of the treatment plan, didn't create a treatment plan for chronic pain therapy, and didn't perform a risk assessment. Respondent increased Patient 3's prescription to 60 tablets of 80 mg. OxyContin per month. At that point, assuming Patient 3 was taking the medications as prescribed, Patient 3 was receiving an MED of 300 along with 8 mg. of Ativan per day.

41. On April 4, 2016, Respondent documented that he saw Patient 3 to refill his pain medications. Respondent copied the subjective note from March 16, 2016, which stated that Patient was receiving OxyContin 60 mg and needed a higher dose of OxyContin, despite having already increased the OxyContin dose at the March 2016 visit. Respondent copied the objective

portion of the April 4, 2016 note from the March 16, 2016, note. Respondent performed no analysis on whether the increased OxyContin prescription was helping Patient 3.

42. On May 9, 2016, Respondent next documented that he saw Patient in clinic for chronic pain management. Respondent documented that Patient 3's back pain was 10/10, that Patient 3 ran out of both OxyContin and Percocet 2 days ago, and that Patient had diarrhea and vomiting. Respondent noted that the diarrhea started when Patient 3 ran out of medications, possibly showing evidence of opiate withdrawal. Respondent documented that he did not perform a back examination because Patient 3 was uncomfortable due to diarrhea. Despite having Patient 3 sign a controlled drug agreement in January 2016, there is no documentation that Respondent questioned Patient 3 for overusing his medications. Respondent didn't document creating a treatment plan, performing a periodic review of that treatment plan, performing a substance abuse history and performing a risk assessment, despite Patient 3 stating that he was running out of medications early. Respondent did not refer Patient 3 to substance abuse treatment.

43. Respondent next documented that he saw Patient 3 in clinic on May 13, 2016. Respondent documented that Patient 3 was present to get a lorazepam refill because he had forgotten to ask for the medication on May 9, 2016. Respondent refilled Patient 3's lorazepam. On May 19, 2016, Respondent documented that Patient 3 went to the emergency room for shortness of breath the night before. Respondent noted that Patient 3 was an alcoholic who was in rehab earlier this month but self reported that he drank alcohol last night. Respondent documented a normal physical examination with the exception of shingles on Patient 3's right upper back. In the plan, Respondent noted that a urine drug screen was positive only for opioids despite Respondent also refilling Patient 3's lorazepam six days earlier. Respondent didn't document a periodic review, didn't address Patient 3's past alcoholism and overuse of medications, and didn't perform an adequate evaluation of the Patient 3's progress on chronic pain therapy. On or about May 22, 2016, Patient 3 died.

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Patient 4

44. On or about May 6, 2014, Respondent first saw Patient 4 in his clinic. At the time, Patient 4 was being prescribed clonazepam (30 – 1 mg. tablets), zolpidem tartrate (30 – 12.5 mg. tablets), and lisdexamfetamine (Vyvanse) (30 – 70 mg. tablets) on a monthly basis by another physician, Patient 4's psychiatrist. Between January 1, 2014, and May 6, 2014, Patient 4 had also received three separate hydrocodone with acetaminophen prescriptions from three different medical providers. Patient 4 reported that he had hurt his back moving furniture in January, that he had tried tramadol and flexeril, and that he had an MRI that showed old prolapsed disks. Patient 4 did not inform Respondent that he was receiving clonazepam, zolpidem tartrate, and lisdexamfetamine. Patient 4 did not inform Respondent that he had also received hydrocodone with acetaminophen from other sources. Patient 4 reported that he had daily, constant low back pain, and that he was a retired oncologist. Respondent documented that Patient 4 had non tender low back pain with reasonable range of motion. Respondent documented that Patient 4 would return as needed and that he would be seeking physical therapy. On May 6, 2014, Respondent prescribed 60 tablets of 10/325 mg. hydrocodone with acetaminophen to Patient 4. Despite starting opiate therapy, Respondent didn't document a treatment plan for chronic pain therapy, didn't perform an opioid risk assessment, didn't document an adequate indication for opiate therapy, and didn't perform a review of non-pharmacologic therapies with Patient 4. Respondent didn't perform an initial physical examination, didn't obtain medical records from Patient 4's previous providers, and didn't verify the medications that Patient 4 was actually being prescribed, which included Ambien, Klonopin, and Vyvanse, before he prescribed narcotics. Respondent did not have Patient 4 sign a pain contract or document providing informed consent including the risks, benefits, and possible side effects of opiate treatment prior to initiating opiate therapy. At his subject interview with the Medical Board on April 6, 2018, Respondent acknowledged that Patient 4 was at a higher risk of complications when prescribed narcotics because he was already being prescribed two sedatives by another physician.

45. Respondent next saw Patient 4 in his clinic on June 19, 2014. Respondent documented that Patient 4 needed a refill of Norco, that Patient 4 had occasional headaches which

go "away with norco(sic)," had a family history of diabetes, and wanted a PSA (prostate-specific antigen) test performed. Respondent documented that Patient 4 wanted a refill of Norco for three months and that he used it for back pain. Respondent documented performing a physical examination and that the results of the physical examination were normal. Respondent didn't document Patient 4's pain level, pain severity nor perform a pain assessment. Respondent prescribed 30 pills of 10/325 mg. pills of hydrocodone with acetaminophen with 2 refills to Patient 4. Respondent was still not aware of Patient 4's other controlled substance prescriptions, still had not obtained medical records from other providers, and did not document a treatment plan for chronic pain management. Patient 4 filled the June 19, 2014, prescription and refills on or about June 19, 2014, on or about July 18, 2014, and on or about July 31, 2018.

46. Respondent next saw Patient 4 in his clinic on September 8, 2014. Respondent documented that Patient 4 was present for a medication refill of his Norco. Respondent documented a treatment plan that included refilling Norco and prescribed 60 tablets of 10/325 mg. hydrocodone with acetaminophen. Respondent did not provide informed consent, did not obtain medical records on Patient 4 from other medical providers, and did not document that he was aware of Patient 4's other prescriptions which included Ambien, Klonopin, and Vyvanse. Respondent did not perform a pain assessment and did not perform a physical examination.

47. Respondent next saw Patient 4 in his clinic on October 7, 2014. At this visit, Respondent had Patient 4 sign a controlled drugs contract which set forth informed consent including risks and benefits of controlled substances, and the contract specifically notified Patient 4 that medications would not be refilled early, that Patient 4 would not receive controlled substances from any other provider except for Respondent with the only exception being medications prescribed at a hospital or on-call physician appointed by Respondent, and that violation of any term of the controlled drugs contact could be grounds for immediate termination of the prescriptions. Respondent did not perform a pain assessment, did not perform a physical examination, did not obtain medical records from Patient 4's other providers, did not verify the medications that Patient 4 was actually taking, and did not document that Patient 4 was taking Ambien, Klonopin, and Vyvanse from another medical provider. Respondent's treatment plan

now stated that Patient 4 would be prescribed 100 tablets of 10/325 mg. hydrocodone with acetaminophen with two refills. There is no documentation in the medical records that supports an increase in Patient 4's dosages of hydrocodone with acetaminophen.

48. Respondent next saw Patient 4 in his clinic on October 22, 2014. Patient 4 reported that Patient 4's wife had used "some of his Norco so has none left (missing 40)". Respondent didn't perform a pain assessment, didn't perform a physical examination, and didn't document admonishing Patient 4 for being in violation of the controlled drugs contract signed October 7, 2014. Respondent prescribed 60 tablets of 10 mg. oxycodone HCL to Patient 4 and noted that Patient 4 would return on November 4, 2014, for a refill of his Norco. Respondent didn't document why it would be appropriate to prescribe two short-acting opiate medications, oxycodone and Norco, at the same time, nor provide an indication for why oxycodone would be appropriate to prescribe to Patient 4. There is no documentation indicating that Respondent was aware that Patient 4 was still continuing to receive Ambien, Klonopin, and Vyvanse prescriptions from another medical provider.

49. Respondent next saw Patient 4 in his clinic on November 14, 2014. Respondent documented that Patient 4 was present to refill his Norco, that he didn't care for the oxycodone, and that his pain level was the same. Respondent didn't perform a pain assessment. Respondent documented that Patient 4 had a non-tender lower back with reasonable range of motion. Respondent documented that Norco was not prescribed on November 14, 2014, but Patient 4 filled a 100 pills of 10/325 mg. hydrocodone with acetaminophen on November 15, 2014, showing that entry to be an error in Respondent's medical records.[4] At the subject interview Respondent acknowledged that the medical records for Patients 1, 2, 3, 4, 5, and 6, at times contained notes that prescriptions were not prescribed at a visit when in fact the prescriptions were filled.

50. Pharmacy records show that Patient 4 filled or refilled Respondent's prescription for 100 pills of 10/325 mg. hydrocodone with acetaminophen on 8 separate occasions between

[4] At the subject interview Respondent acknowledged that the medical records for Patients 1, 2, 3, 4, 5, and 6, at times contained notes that prescriptions were not prescribed at a visit when in fact the prescriptions were filled.

December 11, 2014, and July 5, 2015. Medical records show that Patient 4 saw Respondent in clinic on 8 separate occasions between December 11, 2014, and July 5, 2015. The progress notes are often sparse, appeared to be duplicative, and lack evidence of a periodic review of Patient 4's treatment plan for chronic pain therapy. On March 9, 2015, Respondent documented that Patient 4's pain level was "7" but that Patient 4 was here to "refill his norco, doing fine". Respondent didn't document why it is possible that Patient 4 is reporting a pain level of "7" but was doing fine. Respondent then documented in the medical records that Patient 4's pain level was "8" on April 8, 2015, May 7, 2015, and, June 4, 2015. Respondent continued to document on those dates that Patient 4 was here to "refill is norco, doing fine" without explaining the incongruity of Patient 4's pain level. On July 3, 2015, Respondent documented that Patient 4 was reporting his pain level as "9" but that he was, "doing fine." Aside from documenting that Patient 4 had a "non tender lower back with reasonable range of motion" on December 11, 2014, Respondent did not perform a physical examination between December 11, 2014, and July 5, 2015. Respondent did not document that Patient 4 was continuing to receive Ambien, Klonopin, and Vyvanse prescriptions from another medical provider.

51. On August 3, 2015, Respondent documented seeing Patient 4 in his clinic. Respondent documented that Patient 4 was there to "refill his norco, doing fine," and his pain level was "8". Respondent documented that Patient 4 was well nourished, well developed, and in no acute distress. Respondent documented that Patient 4 never went and saw a neurologist despite Respondent repeatedly documenting that Patient 4 had been promising to see a neurologist for the past 6 months. Respondent documented that Patient 4's psychiatrist was on vacation and that Patient 4 needed a refill of Vyvanse which he took for ADD. Respondent diagnosed lumbago (lower back pain) and, ADHD. Respondent prescribed 100 tablets of 10/325 mg. hydrocodone with acetaminophen and 30 tablets of 70 mg. Vyvanse. Respondent did not document whether Patient 4 was in violation of his drug contract for not having disclosed he was receiving controlled substances from another physician, did not document whether he was now aware that Patient 4 was receiving Ambien and Klonopin, and, did not perform a periodic review of Patient 4's progress. Respondent did not document performing a history and physical related

to Patient 4's Vyvanse prescription, and didn't obtain medical records from Patient 4's psychiatrist. At the Respondent's subject interview, he admitted that Patient 4 gave Respondent his own diagnosis of ADHD, that Respondent didn't establish whether the diagnosis was correct, and that Respondent took his, "patient's word for it," when he prescribed Vyvanse. Respondent acknowledged that he knew Vyvanse was a controlled substance.

52. After August 3, 2015, Respondent continued prescribing 100 tablets of 10/325 mg. hydrocodone with acetaminophen and 30 tablets of 70 mg. Vyvanse to Patient 4 on a regular monthly basis through October 14, 2016. On February 2, 2016, Respondent saw Patient 4 in office. No chief complaint was recorded. Respondent documented that Patient 4 was present to, "refill his norco, doing fine." Respondent noted Patient 4 still hadn't seen his neurologist, was still putting off back surgery and that his pain level was "7". Respondent noted that Patient 4 talked to his psychiatrist on the phone but that he came to Respondent for his refills of Vyvanse. Patient 4 requested he be prescribed Adderall. Respondent documented that Patient 4 was on Ambien, Norco, and Adderall but documented that he didn't refill the medications. Pharmacy records show that Respondent began prescribing Ambien, with the patient filling Respondent's prescription on February 25, 2016. There is no documentation on whether Patient 4 was in violation of his drug contract. There is no documentation supporting a prescription for Ambien contained in the medical records.

53. On April 18, 2016, Respondent documented that he refilled Patient 4's Norco prescription, Ambien prescription, and Vyvanse prescription. On April 27, 2016, Respondent documented that he was now refilling Patient 4's clonazepam prescription. There was no documentation that Respondent found Patient 4 in violation of his controlled drug contract despite having just informed Respondent that he was taking clonazepam. Respondent began prescribing clonazepam on a monthly basis.

54. According to pharmacy records, Respondent continued to prescribe hydrocodone with acetaminophen, clonazepam, Vyvanse, and zolidem tartrate to Patient 4 through March of 2018. Respondent has not reduced nor tapered any of those prescriptions. A review of the medical records throughout Respondent's treatment of Patient 4, in addition to the specific records noted

above, showed that Respondent rarely performed physical examinations, never documented a treatment plan for chronic pain management, never recommended or documented recommending non-pharmacologic therapies, and never tapered Patient 4 off of controlled substances. Respondent's medical records between May 2014 and September 2016 were often cut and pasted, the records made references to previous notes that lack the referenced information, and the records showed that Respondent failed to perform risk assessments when he titrated new medications. On June 8, 2016, Patient 4 reported that he had to leave his house pursuant to a court order and was unable to remove his medications and needed a refill of all of his medications. Respondent provided Patient 4 a refill of his Norco, Vyvanse and Clonazepam prescriptions despite Patient 4 being in violation of his drug contract. Respondent didn't document why Patient 4 was being removed from his house pursuant to a court order, whether the removal was due to the prescriptions that he was providing, and whether his treatment was causing Patient 4 harm. Respondent admitted during his subject interview with the Medical Board that he never spoke to Patient 4's psychiatrist between 2014 and 2016 despite learning during that time that Patient 4 was receiving prescriptions from the psychiatrist during that time.

Patient 5

55. On July 18, 2014, Respondent first saw Patient 5 in his clinic. Patient 5 had previously been seen by a different medical provider for chronic pain therapy but reportedly could no longer see that provider due to cost. Respondent documented that Patient 5 had chronic pain due to a back injury and that he had left knee pain. Respondent documented that Patient 5 was well nourished, well developed, and in no acute distress. Respondent documented that Patient 5 had a "surgical scar in lumbar area, tender lumbar, limited range of motion." Respondent diagnosed Patient 5 with chronic pain and prescribed 120 tablets of 30 mg. oxycodone HCL and 30 tablets of 30 mg. morphine sulfate ER. The prescription was to last 30 days. Assuming that the prescription was taken as prescribed, the ("MED") would be 210. Patient 5 had previously received a monthly prescription of 120 pills of 30 mg. oxycodone HCL and 90 tablets of 30 mg. morphine sulfate ER from his previous medical provider. Respondent didn't document a treatment plan for chronic pain management, didn't document a substance

abuse history, didn't perform a risk assessment, and, didn't provide informed consent including the risks and benefits of chronic pain therapy. While Respondent documented that Patient 5 suffered from back pain, he didn't perform a pain assessment or document discussing non-controlled substance treatment options. Respondent obtained handwritten medical records from Patient 5's prior treating physician.

56. Respondent next documented that he saw Patient 5 in clinic on August 15, 2014, for medication refills. Respondent documented that Patient 5 wanted to discontinue the morphine and just use oxycodone. Respondent documented that Patient 5 suffered from chronic pain and he prescribed 120 pills of 30 mg. oxycodone HCL. This reduced Patient 5's MED to 180. Respondent also had Patient 5 sign a drug contract. The controlled drug contract signed August 15, 2014, set forth informed consent including risks and benefits of controlled substances, and the contract specifically notified Patient 5 that medications would not be refilled early, that Patient 5 would not receive controlled substances from any other provider except for Respondent with the only exception being medications prescribed at a hospital or on-call physician appointed by Respondent, and that violation of any term of the controlled drugs contact could be grounds for immediate termination of the prescriptions. Respondent did not document a pain assessment, plan for controlled substance abuse prescribing, or perform a physical examination at that time.

57. Respondent next documented seeing Patient 5 in his clinic on October 22, 2014. Respondent documented that Patient 5 was splitting his pills to make them last the month, indicating he was possibly overusing medications, and that Patient 5 would like to have 180 30 mg. oxycodone pills per month. Respondent did not document performing a pain assessment, treatment for chronic therapy, or perform a periodic review. Respondent prescribed 180 pills of 30 mg. oxycodone HCL to last a month as requested by Patient 5 and provided no documentation to support that this increase in dosage was medically necessary. Patient 5's MED increased to 270. Respondent did not document that he admonished Patient 5 for violating the controlled drug contract by running out of medications early. Respondent continued the 180 tablets of 30 mg. oxycodone HCL prescription for 5 months.

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58. On February 17, 2015, Respondent documented that he saw Patient 5 in his clinic. Respondent noted that Patient 5 had to go to the ER (emergency room) for a "lock up" back, that he received a shot of morphine, and received 8 tablets of hydrocodone with acetaminophen. Respondent noted that Patient 5 was there to refill meds and, "doing okay on present doses." Respondent noted that Patient 5 had a pain level of 8/10 for his lower back, left leg, and knee. Respondent documented a back examination. Respondent then documented a plan where he was reducing oxycodone and starting OxyContin ER. Respondent didn't document why he was now prescribing OxyContin ER. Between February 20, 2015, and June 11, 2015, Respondent prescribed OxyContin ER and oxycodone. Respondent lowered the dose of oxycodone during that time.

59. On June 18, 2015, Respondent saw Patient 5 in his clinic. Respondent documented that Patient 5 was present to refill his medications and, "doing okay on present doses." Despite documenting that Patient 5 was doing okay, Respondent documented that Patient 5's pain level was "10/10" for lower back, left leg, and knee. Respondent documented that the "back is tender upper thorax down to sacrum," and that "(l)ateral bends increase pain." Respondent failed to document that he was discontinuing OxyContin ER, only documenting that he was restarting Morphine Sulfate ER. Respondent prescribed 120 tablets of 30 mg. oxycodone HCL and 60 tablets of 30 mg. Morphine Sulfate ER. Patient 5's MED was now 240. Respondent failed to explain why he was restarting Morphine Sulfate ER, failed to document a treatment plan for chronic pain therapy, and failed to perform a substance abuse history. Respondent continued to prescribe morphine sulfate and oxycodone through December 2015 on a monthly basis.

60. Between January 8, 2016, and August 5, 2016, Respondent prescribed or refilled the following medications to Patient 5 as listed in the following table.

Date Filled	Medication	Quantity	Dosage	Schedule
1-8-2016	Morphine Sulfate	60	60 mg.	II
1-8-2016	Oxycodone HCL	120	30 mg.	II
1-9-2016	Alprazolam	30	2 mg.	IV

2-4-2016	Oxycodone HCL	30	30 mg.	II
2-8-2016	Morphine Sulfate	60	60 mg.	II
2-9-2016	Oxycodone HCL	120	30 mg.	II
2-20-2016	Alprazolam	30	2 mg.	IV
3-9-2016	Morphine Sulfate	60	60 mg.	II
3-9-2016	Oxycodone HCL	120	30 mg.	II
4-11-2016	Morphine Sulfate	60	60 mg.	II
4-11-2016	Oxycodone HCL	120	30 mg.	II
5-10-2016	Morphine Sulfate	60	60 mg.	II
5-10-2016	Alprazolam	30	2 mg.	IV
5-10-2016	Oxycodone HCL	120	30 mg.	II
6-7-2016	Oxycodone HCL	120	30 mg.	II
6-7-2016	Alprazolam	30	2 mg.	IV
6-8-2016	Morphine Sulfate	60	60 mg.	II
7-8-2016	Morphine Sulfate	60	60 mg.	II
8-5-2016	Alprazolam	20	2 mg.	IV
8-5-2016	Oxycodone HCL	120	30 mg.	II

61. Assuming Patient 5 was taking the medications as prescribed (4-30 mg. oxycodone HCL and 2-60 mg. morphine sulfate per day) he had an MED of 300 along with 2 mg. of a sedative in the form of alprazolam. On January 8, 2016, Respondent documented that he saw Patient 5 in clinic for medication refills, that Patient 5 was "doing okay on present doses," but that Patient 5's pain level today was "10/10" for lower back, left leg, and knee. Respondent documented that Patient 5 reported he, "(a)lso would like to take something to help him sleep." Respondent documented that Patient 5 reported, "(h)is mother loaned him a Xanax and it worked well (4 mg.)." Respondent noted that Patient 5 was well nourished, well developed, and in no acute distress, had a tender left knee without swelling a tender lumbar spine with good range of motion. Respondent did not document that he admonished Patient 5 for taking medications in

violation of the controlled drug agreement, and instead began prescribing alprazolam to Patient 5 despite the drug contract specifically saying, "I will not request or accept controlled substance medication from any other physician or individual while I am receiving medication from Dr. Gilliam." Respondent did not attempt to try any non controlled drug therapies to help Patient 5 sleep and did not refer Patient 5 to a medical specialist to work up his sleep issues. Respondent did not document any indication for prescribing alprazolam to Patient 5, did not document that he discussed the increased risk benzodiazepines pose to a patient already on chronic opiate therapy, and Respondent did not document a treatment plan aside from prescribing and refilling medications. While Respondent performed a pain assessment, he did not perform a periodic review to actually determine if chronic pain therapy was working for Patient 5.

62. On February 3, 2016, Respondent next documented that he saw Patient 5 in clinic. Respondent documented that Patient 5 had reported he was in a motor vehicle accident six days earlier. Respondent documented that Patient 5 stated he was a front seat passenger, wearing a seatbelt and that the impact point was on the side of the vehicle where he was sitting. Respondent documented that Patient 5 reported lower back pain, couldn't sleep the night prior and that Patient 5 did not go to the ER (emergency room). Respondent documented that Patient 5 was reporting that he had used up all his oxycodone early because he was taking it every three hours. Respondent noted no neck or shoulder pain in the note. Respondent did not document that he requested a copy of a motor vehicle accident report, did not document that he admonished Patient 5 for requesting an early refill, and did not document that he questioned Patient 5 regarding why he didn't seek medical help at any point in the six days prior. Respondent prescribed an early prescription of 30 pills of 30 mg. oxycodone HCL despite the drug contract stating that medications will not be refilled if, "I run out early."

63. A review of the medical and pharmacy records after August 2016, show that Respondent began tapering Patient 5 down on opiate therapy. For example, on or about January 28, 2017, Respondent prescribed 84 tablets of 30 mg. oxycodone and 56 tablets of 60 mg. morphine sulfate. On or about February 8, 2017, Respondent continued to prescribe 30 tablets of 2 mg. alprazolam. At that point, assuming Patient 5 was taking the medication over a 28-day

period as prescribed, he was at an MED of 255, while still taking a sedative in the form of alprazolam. Respondent continued to document that Patient 5 was running out of medications early. For example, on November 4, 2016, Patient 5 reported that he was seeking a doctor in Sacramento where he reported that he currently lived (Respondent works out of a Monterrey, California office) but couldn't find anyone. Patient 5 reported he ran out of meds. Respondent filled Patient 5's morphine sulfate and oxycodone prescriptions despite another violation of the controlled drug agreement and he didn't document any consequences in the medical record for the violation. On or about November 4, 2016, Respondent had prescribed 84 tablets of 30 mg. oxycodone and 56 tablets of 60 mg. morphine. On November 30, 2016, Patient 5 again appeared at Respondent's clinic and reported that he ran out of medications 7 days earlier. Assuming that Patient 5 had consumed the entire prescription in 19 days as self-reported based on when he ran out of medications, Patient 5's MED during that time was 360, a significant upward deviation from the 255 MED that was being prescribed. Respondent noted that Patient 5 was requesting an increase in pain medication. While Respondent doesn't increase Patient 5's medications, he continued to prescribe the same amount, didn't document any concerns related to Patient 5 using his medications in a way not intended, and he didn't document any consequences for Patient 5 again being in violation of his controlled drug contract.

64. Based on pharmacy records, by February 2018, Respondent was prescribing 120 tablets of 30 mg. of oxycodone HCL and 30 tablets of 2 mg. alprazolam to Patient 5. At this point Patient 5's MED was down to 180 per day, while still receiving alprazolam. In addition to the records specifically noted above, between July 18, 2014, and November 30, 2016, there was a continued lack of evidence to support an indication for controlled substance prescribing, and a continued lack of documentation related to treatment plans for chronic pain therapy. Despite repeated violations of the controlled drug agreement, Respondent continued to prescribe Schedule II narcotics and Schedule IV sedatives to Patient 5 on a monthly basis. There is no indication in the medical records that Respondent continued to try non-opioid or non-pharmacologic options with the goal of getting Patient 5 off of all opiate therapy. While Respondent did eventually lower Patient 5's MED from 210 to 180 over a three-and-half year period, Respondent also

significantly increased Patient 5's MED load at times during that three-and-half year period. Respondent never appeared to perform a periodic review of Patient 5's progress on opiate therapy and the documentation lacks basic information on Patient 5's functionality on opiate therapy. Respondent's medical progress notes are often copied and pasted from previous visits.

Patient 6

65. On July 11, 2014, Respondent first saw Patient 6 in his office. Respondent documented that Patient 6 had previously suffered panic attacks for ten years, was off medications at the moment, had daily anxiety, and worked nights. Respondent documented a physical that included that Patient 6 was well nourished, well developed, and in no acute distress. Patient 6 was documented to be alert and oriented times three. Respondent documented that he assessed her as suffering from panic attacks and prescribed 30 tablets of .5 mg. alprazolam. Respondent did not have medical records from Patient 6's previous medical providers nor did he contact Patient 6's previous medical providers. At the subject interview on April 6, 2017, with the Medical Board, Respondent acknowledged that he didn't perform a neurologic examination beyond looking at Patient 6's appearance. Respondent stated he generally provided anxiety management recommendations to Patient 6 like to avoid stimulants, to perform regular exercise, and do meditation. There is no documentation that Respondent made those recommendations in this case as the treatment plan just included prescribing Xanax. Respondent failed to document a history of Patient 6's panic attacks and failed to document a treatment plan before prescribing Xanax. Respondent failed to document that he provided informed consent, including the risks and benefits of a controlled substance prescription.

66. Respondent next saw Patient 6 on July 30, 2014. Respondent documented that Patient 6 "likes her Xanax, wants to stay with this rather try clonazepam." Respondent didn't document any objective findings, continued to not document a complete history for panic attacks, and documented a plan that Patient 6 would return in 4 weeks and he prescribed 90 pills of .5 mg. alprazolam to Patient 6. There is no documentation that supports a tripling of Patient 6's alprazolam prescription. There is no assessment documented on whether or not Respondent's prescribing of alprazolam is actually treating Patient 6's anxiety related issues other than Patient 6

"likes her Xanax." Respondent did have Patient 6 sign a controlled drug contract. The controlled drugs contract set forth informed consent, including risks and benefits of controlled substances, and the contract specifically notified Patient 6 that medications would not be refilled early, that Patient 6 would not receive controlled substances from any other provider except for Respondent with the only exception being medications prescribed at a hospital or on-call physician appointed by Respondent, and that violation of any term of the controlled drugs contact could be grounds for immediate termination of the prescriptions.

67. Respondent next saw Patient 6 on August 27, 2014. Respondent documented that Patient 6 was present to refill her medications, and that she was still up at night with palpatations. Respondent documented that Patient 6 reported a history of fibromyalgia but that she was not taking medications right now. Patient 6 reported that she might "like to take her old Norco, etc." Respondent did not document any objective findings, continued to document panic attacks in the assessment and documented in his treatment plan that Patient 6 was willing to try clonazepam. Respondent prescribed 30 tablets of .5 mg. clonazepam and 60 tablets of .5 alprazolam. At his subject interview with the Medical Board on April 6, 2017, he explained that he prescribed the two benzodiazepines at the same time to have a long acting and short acting medication as he attempted to transition Patient 6 to just a long acting anxiety medication. This explanation was not documented in Respondent's treatment plan on August 27, 2014. Respondent didn't document an assessment of whether Patient 6's previous Xanax prescriptions were working, and didn't perform a physical examination prior to starting clonazepam.

68. Respondent next documented seeing Patient 6 in clinic on September 17, 2014. Respondent documented that Patient 6 had started the clonazepam but was still using the Xanax. Respondent noted no side effects. Respondent documented that Patient 6 "has fibromyalgia; has been out meds since last year." He noted that she couldn't afford Lyrica and was taking Norco. Respondent documented that Patient 6 noted her pain level was "7/10" and that she "wants to restart the Norco." Respondent documented that she was alert and articulate. At the subject interview with the Medical Board, on April 6, 2017, Respondent admitted that he did not establish the diagnosis of fibromyalgia and that he relied on the Patient reporting that she had a

diagnosis of fibromyalgia. Respondent also relied on medical records from Patient 6's previous provider who diagnosed fibromyalgia but Respondent admitted he had not idea how the previous medical provider actually came up with a diagnosis of fibromyalgia when he reviewed the records. Respondent didn't perform a substance abuse history, didn't perform a physical, didn't document performing a history of Patient 6's fibromyalgia, didn't document recommending non-pharmacological therapies, and failed to establish a medical indication to treat fibromyalgia. At the April 6, 2017, subject interview Respondent acknowledged that he doesn't diagnose fibromyalgia, instead referring patients to a rheumatologist and that he didn't refer Patient 6 to a rheumatologist before prescribing controlled substances. Respondent proceeded to prescribe 30 tablets of 1 mg. of clonazepam, 90 tablets of 10/325 mg. hydrocodone with acetaminophen, and 30 tablets of 350 mg. carisoprodol. Respondent didn't document why he was prescribing carisoprodol. Respondent did not document that he warned Patient 6 about the risks associated with taking opiates and sedatives at the same time.

69. On October 15, 2014, Respondent next saw Patient 6 in clinic. Respondent documented that Patient 6 was doing better on 1 mg. clonazepam but still had some bad days. Respondent noted that she was tired, needed refills of her medications for fibromyalgia and that she felt the Norco was helping her a lot. Respondent did not do an assessment on whether carisoprodol is necessary. Respondent documented no new objective findings, and continued to diagnose fibromyositis and panic attacks. Respondent's plan was to have Patient 6 return in four weeks and he prescribed 30 tablets of .5 mg. alprazolam, 30 tablets of 1 mg. clonazepam, 90 tablets of hydrocodone with acetaminophen, and 30 tablets of 350 mg. carisoprodol. Respondent didn't do a pain assessment, didn't perform a history and physical, didn't create a treatment plan for chronic pain therapy, and he continued to prescribe controlled substances without an adequate medical indication.

70. Between October 2014, and April 2018, Respondent continued to prescribe monthly prescriptions of hydrocodone with acetaminophen, carisoprodol, and clonazepam to Patient 6. Respondent has continued and/or increased these medications for the past four years without any evidence of weaning Patient 6 off of these medications. For example, on or about July 12, 2016,

Respondent prescribed 30 tablets of 350 mg. carisoprodol, 90 tablets of 10/325 mg. hydrocodone with acetaminophen, and 30 tablets of 1 mg. clonazepam to Patient 6. For example, on or about February 8, 2017, Respondent having increased the dosages, was prescribing 30 tablets of 350 mg. carisoprodol, 56 tablets of 1 mg. clonazepam, and, 112 tablets of 10/325 mg. hydrocodone with acetaminophen to Patient 6. Finally, by way of example, on or about July 24, 2017, Respondent having again increased the dosages, was prescribing 30 tablets of 350 mg. carisoprodol, 84 tablets of 1 mg. clonazepam, and, 112 tablets of 10/325 mg. hydrocodone with acetaminophen to Patient 6. At the subject interview of Respondent on April 6, 2018, Respondent stated he believed there was no limit on the length of time carisoprodol can be prescribed, despite carisoprodol only being recommended to be used for used for short-term acute pain in periods of three weeks or less.[5]

71. In reviewing the Respondent's medical records between November 11, 2014, and November 11, 2016, Respondent often copied and pasted electronic notes from previous encounters. Respondent often ignored warning signs that Patient 6 was not compliant with the controlled drug agreement including documenting on August 11, 2016, September 8, 2016, October 10, 2016, and November 11, 2016, that Patient 6 was running out of her Norco prescription early. Respondent did not document whether he took any action against Patient 6 for overusing her medications. Respondent often documented in his notes that he referred back to previous notes for information where no such information had actually been documented in the previous notes, Respondent never performed a physical examination after the first visit, never referred Patient 6 in four years to a specialist to determine or confirm the diagnoses of panic attacks and fibromyositis, and made no documentation regarding whether or not he recommended non-pharmacologic therapies. Respondent failed to perform a periodic assessment of his treatment plan, which was often just that he was prescribing medications, to determine if he should continue the concomitant use of an opiate and two sedatives. Respondent failed to document a plan of care for carisoprodol despite prescribing it for four years to Patient 6.

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[5] https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009466/?report=details.

72. Respondent's license is subject to discipline due to his care and treatment of Patients 1, 3, 4, 5, and 6, separately and collectively, in the following ways:

a.) As set forth above, Respondent's care and treatment of Patient 1 represents gross negligence because he failed to document a history and physical examination, a treatment plan, and opioid risk assessments during the care of Patient 1. Furthermore, Respondent failed to recommend the use of non-pharmacologic therapies, and failed to perform an appropriate periodic review of Patient 1's progress on chronic pain therapy;

b.) As set forth above, Respondent's care and treatment of Patient 3 represents gross negligence because he failed to appropriately evaluate the patient, including the patient's past history of methadone prescriptions and alcohol abuse, failed to document a treatment plan which included dealing with Patient 3's past-history of substance abuse, and failed to adequately address Patient 3's lack of compliance while on a chronic pain regimen by failing to perform an appropriate periodic review of Patient 3's progress;

c.) As set forth above, Respondent's care and treatment of Patient 4 represents gross negligence because he failed to document an initial evaluation treatment plan and perform an opioid abuse risk assessment and prescribed opioids without adequate documentation of medical indication for treatment. Furthermore, Respondent failed to perform physical examinations and failed to perform periodic review of Patient 4's progress on chronic pain management therapy. Finally, Respondent failed to document a continuing plan of care and made no recommendations for the use of non-pharmacologic therapies;

d.) As set forth above, Respondent's care and treatment of Patient 5 represents gross negligence because he failed to document an initial evaluation, a medical indication for treatment and develop a treatment plan before beginning opiate therapy. Furthermore, Respondent never performed a periodic review of Patient 5's treatment plan to determine if chronic pain management therapy was

warranted despite Patient 5 constantly running out of medication early, and he never recommended the use of non-pharmacologic therapies; and,

e.) As set forth above, Respondent's care and treatment of Patient 6 represents gross negligence because he never documented an initial evaluation and treatment plan, before prescribing controlled substances. Furthermore, Respondent continued to prescribe controlled substances despite never performing a physical examination after the first visit, never documenting a plan of care for the use of opioids and carisoprodol, never documenting the recommendation of non-pharmacologic therapies and never documenting a periodic review of Patient 6's progress on chronic pain management.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

73. Respondent's license is subject to disciplinary action under section 2234 (c) in that he engaged in repeated negligent acts during the care and treatment of Patients 1, 2, 3, 4, 5, and 6. The circumstances are as follows:

74. Complainant realleges paragraphs 19 through 72, and those paragraphs are incorporated by reference as if fully set forth herein.

Patient 2

75. On October 10, 2014, Respondent documented that he first saw Patient 2 in his clinic. Patient 2 reported that he was present to establish care and refill his Norco prescription after his previous medical provider had converted her office to a different type of practice and terminated him from the practice. Respondent documented that Patient 2 had a pain complaint of back pain and neck pain from Degenerative Disc Disease. Respondent began treating Patient 2's chronic pain with a prescription of 120 tablets of 10/325 mg. hydrocodone with acetaminophen. Respondent provided on-going pain management care to Patient 2 between October 10, 2014, and March 31, 2018. By September 26, 2016, Respondent was prescribing 150 tablets of 10/325 mg. hydrocodone with acetaminophen, 56 tablets of 100 mg. morphine sulfate, and 60 tablets of 2 mg. clonazepam. A review of the medical records kept for Patient 2 between October 10, 2014, and

September 26, 2016, showed a medical indication for chronic pain management prescribing, specifically an on-going ulcer on Patient 2's right foot and back and neck pain caused by Degenerative Disc Disease. Patient 2 also suffered from diabetes which complicated his healing process and exacerbated his pain conditions. A review of the medical records between October 10, 2014, and September 26, 2016, did show excess copying of notes. Examples include but are not limited to, cutting and pasting the same subjective section on the July 28, 2016, and August 29, 2016, progress notes. Examples include but are not limited to, cutting and pasting the subjective sections on the July 1, 2015, July 10, 2015, August 10, 2015, and September 10, 2015, progress notes. Finally, by way of example but not limited to, cutting and pasting the subjective sections on the January 12, 2015 and February 12, 2015, progress notes.

76. Respondent committed the following repeated negligent acts during the care of Patients 1, 2, 3, 4, 5, and, 6:

a.) Respondent failed to adequately perform and/or document performing physical examinations and objective pain assessments on Patient 1 despite prescribing controlled substances;

b.) Respondent failed to adequately perform and/or document performing physical examinations and objective pain assessments on Patient 3 despite prescribing controlled substances;

c.) Respondent failed to adequately perform and/or document performing physical examinations and objective pain assessments on Patient 4 despite prescribing controlled substances;

d.) Respondent failed to adequately perform and/or document performing physical examinations and objective pain assessments on Patient 5 despite prescribing controlled substances;

e.) Respondent failed to adequately perform and/or document performing physical examinations and objective pain assessments on Patient 6 despite prescribing controlled substances;

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f.) Respondent failed to perform and/or document performing a treatment plan with stated goals and objectives for Patient 1 including pain assessments, functionality assessments, and goals to minimize chronic pain therapy despite prescribing controlled substances;

g.) Respondent failed to perform and/or document performing a treatment plan with stated goals and objectives for Patient 3 including pain assessments, functionality assessments, and goals to minimize chronic pain therapy despite prescribing controlled substances;

h.) Respondent failed to perform and/or document performing a treatment plan with stated goals and objectives for Patient 4 including pain assessments, functionality assessments, and goals to minimize chronic pain therapy despite prescribing controlled substances;

i.) Respondent failed to perform and/or document performing a treatment plan with stated goals and objectives for Patient 5 including pain assessments, functionality assessments, and goals to minimize chronic pain therapy despite prescribing controlled substances;

j.) Respondent failed to perform and/or document performing a treatment plan with stated goals and objectives for Patient 6 including pain assessments, functionality assessments, and goals to minimize chronic pain therapy despite prescribing controlled substances;

k.) Respondent failed to perform and/or document performing a periodic review and ongoing monitoring of Patient 1's progress on chronic pain therapy;

l.) Respondent failed to perform and/or document performing a periodic review and ongoing monitoring of Patient 3's progress on chronic pain therapy;

m.) Respondent failed to perform and/or document performing a periodic review and ongoing monitoring of Patient 4's progress on chronic pain therapy;

n.) Respondent failed to perform and/or document performing a periodic review and ongoing monitoring of Patient 5's progress on chronic pain therapy;

o.) Respondent failed to perform and/or document performing a periodic review and ongoing monitoring of Patient 6's progress on chronic pain therapy;

p.) Respondent copied and pasted progress notes from previous clinical visits that failed to provide an adequate representation of how Patient 1 was doing on chronic pain management therapy;

q.) Respondent copied and pasted progress notes from previous clinical visits that failed to provide an adequate representation of how Patient 2 was doing on chronic pain management therapy;

r.) Respondent copied and pasted progress notes from previous clinical visits that failed to provide an adequate representation of how Patient 3 was doing on chronic pain management therapy;

s.) Respondent copied and pasted progress notes from previous clinical visits that failed to provide an adequate representation of how Patient 4 was doing on chronic pain management therapy;

t.) Respondent copied and pasted progress notes from previous clinical visits that failed to provide an adequate representation of how Patient 5 was doing on chronic pain management therapy; and,

u.) Respondent copied and pasted progress notes from previous clinical visits that failed to provide an adequate representation of how Patient 6 was doing on chronic pain management therapy.

THIRD CAUSE FOR DISCIPLINE

(Furnishing Dangerous Drugs without examination)

77. Respondent's license is subject to disciplinary action under section 2242 of the Code in that he repeatedly prescribed dangerous drugs without an appropriate prior examination and a medical indication.

78. Complainant realleges paragraphs 19 through 76, and those paragraphs are incorporated by reference as if fully set forth herein.

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FOURTH CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Records)

79. Respondent's license is subject to disciplinary action under section 2266 of the Code in that he kept inadequate and inaccurate medical records while prescribing controlled substances to Patients 1, 2, 3, 4, 5, and 6. The circumstances are as follows:

80. Complainant realleges paragraphs 19 through 76, and those paragraphs are incorporated by reference as if fully set forth herein.

DISCIPLINARY CONSIDERATIONS

81. To determine the degree of discipline, if any, to be imposed on Respondent Richard Leonard Gilliam, M.D., Complainant alleges that on or about August 1, 2005, in a prior disciplinary action entitled *In the Matter of the Accusation Against Richard Leonard Gilliam, M.D.*, before the Medical Board of California, in Case No. 16-2002-138462, a Public Reprimand was issued against Respondent's license for out-of-state discipline pursuant to Business and Professions Code section 141 and 2305. In the underlying Decision and Order, which became effective on or about August 1, 2003, Respondent admitted that in 2002 the State of Maine Board of Licensure entered into a Consent Agreement with Respondent where he agreed to withdraw his pending application for licensure renewal and instead request a medical license in inactive status. Respondent further admitted that the State of Maine Board of Licensure agreed to not pursue further discipline for an incident in 1999 where the Respondent failed to properly diagnose and treat a patient for shock. In order to receive the 2005 Public Reprimand from the California Medical Board, Respondent was required to successfully complete a comprehensive clinical assessment program. That decision is now final and is incorporated by reference as if fully set forth herein.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 85035, issued to Richard Leonard Gilliam, M.D.;

2. Revoking, suspending or denying approval of Richard Leonard Gilliam, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Richard Leonard Gilliam, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: September 17, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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